

Health Related Social Needs (HRSN) Prior Authorization Request -Housing-

Please Fax to 503.850.9398 | Questions call 855.722.8205

****Chart Notes/Relevant Clinical Documentation, Proof of Income (from the last two months), and Lease Agreement Required. If submitting for Home Modification/Remediation, include Scope of Work form****

Full completion of the PA Form and providing required documentation will help to ensure timely processing of this request.

EXPEDITED REQUEST: ☐ Check Here for Imminent Eviction Request
Include a copy of the eviction notice.

Member Information	
Last Name:	First Name:
Insurance ID #:	DOB:
Address:	County:
Phone:	Email:
Preferred Language:	Pronouns:

Requestor Information:	
Requesting Provider/Organization/Member:	Phone:
Address:	Email:

Check here if Requestor will also be Housing Service Provider.

Provider Information (Current Provider That Manages Member's Clinical Risk Factors Related to HRSN)	
Care Provider:	Care Provider Phone:
TIN#:	NPI#:

Benefit Request: Rent/Utilities/Tenancy													
Rent (Max. of 6 Months)/Tenancy Service Name of Landlord: _____ Landlord Contact Number: _____ Amount per month: \$ _____ Size of Home (# of bedrooms): _____	☐ Check For Past Due Rent Indicate the Months Owed/Past Due: <table style="width: 100%; text-align: center;"> <tr> <td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td></tr> <tr> <td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td></tr> </table>	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	Feb	Mar	Apr	May	Jun								
Jul	Aug	Sep	Oct	Nov	Dec								
☐ Utilities (Max. of 6 Months) ☐ Utilities Set-Up	☐ Check Here For Past Due Utilities Indicate the Months Owed/Past Due: <table style="width: 100%; text-align: center;"> <tr> <td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td></tr> <tr> <td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td></tr> </table>	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	Feb	Mar	Apr	May	Jun								
Jul	Aug	Sep	Oct	Nov	Dec								
Storage Fees													
Tenancy Services (Stand Alone)													

Eligibility Criteria (Rent/Utilities/Tenancy)
Member must meet ALL the following requirements. If member does not meet HRSN eligibility, consider applying for HRS Flex Funds: https://yamhillcco.org/wp-content/uploads/YCCO-Flex-Funds-Request-1.pdf
☐ Enrolled in OHP under category CCOA or CCOB -AND- ☐ Below 30% of Median Family Income: Family Size _____ / Annual Family Income \$ _____

-AND-

☐ Currently Housed **-AND-**

☐ Lacks sufficient resources or support networks to prevent homelessness **-AND-**

Meets AT LEAST ONE of the housing-specific clinical risk factors:

- | | |
|---|---|
| ☐ Complex Behavioral Health needs | ☐ Adult 65 years of age or older |
| ☐ Developmental Disability Need | ☐ Child less than 6 years of age |
| ☐ Complex Physical Health Need | ☐ Repeated ED use and crisis encounters |
| ☐ Interpersonal violence experience | ☐ Young Adult with Special health care needs |
| ☐ Need for Assistance with ADLs or eligible for LTSS | ☐ Pregnant/Postpartum |

Benefit Request: Home Modification/Home Remediation

☐ **Medically necessary home modification** ☐ Scope of Work Form Attached

☐ **Medically necessary home remediation** ☐ Scope of Work Form Attached

☐ **Hotel/Motel Stay** (Only available to those who meet the at-risk of homelessness definition AND require a hotel/motel stay while work is being done on their home.)

Eligibility Criteria (Home Modification/Home Remediation)

Member must meet ALL the following requirements.

If member does not meet HRSN eligibility, consider applying for HRS Flex Funds:

<https://yamhillcco.org/wp-content/uploads/YCCO-Flex-Funds-Request-1.pdf>

☐ Enrolled in OHP under category CCOA or CCOB **-AND-**

Be in AT LEAST ONE HRSN covered population

- ☐ Adults or youth discharged from an Institute of Mental Disease (IMD) in past 12 months
- ☐ Adults or youth released from incarceration in past 12 months
- ☐ Individual transitioning to Dual Medicaid/Medicare status
- ☐ Individual currently meets HUD definition of homeless or at risk of homelessness
- ☐ Involved in child welfare including members who have previously been involved with child welfare
- ☐ Young Adults with Special Health Care Needs (ages 19 and 20)

-AND-

Meets AT LEAST ONE of the housing-specific clinical risk factors:

- | | |
|---|---|
| ☐ Complex Behavioral Health needs | ☐ Adult 65 years of age or older |
| ☐ Developmental Disability Need | ☐ Child less than 6 years of age |
| ☐ Complex Physical Health Need | ☐ Repeated ED use and crisis encounters |
| ☐ Interpersonal violence experience | ☐ Young Adult with Special health care needs |
| ☐ Need for Assistance with ADLs or eligible for LTSS | ☐ Pregnant/Postpartum |

-AND-

☐ Needs the home modification/remediation to help or prevent member's health condition

Member Attestations (must be completed in full)

☐ Member has attested to not be receiving duplicative services through other programs OR existing service is not fully meeting Member needs

Member has consented to:

- ☐ Receive approved HRSN Services
- ☐ Be contacted by phone and text by YCCO staff
- ☐ Be contacted by phone by the Housing Service Provider, and related contractors or vendors
- ☐ Be contacted for Housing Care Management (Tenancy Services) (optional)

Expedited- defined as member's life, health, or ability to regain maximum function is in serious jeopardy if determination is not made in the standard time frame.

Request must include supporting documentation to substantiate an expedited review.

Explanation Required:

Additional Comments (Optional):

Additional Info:

Code	Modifiers	Requested Item/Service

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